

FILED JUN 13 1944

Primary Registration District No. 5573

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Grain Valley Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 50 yr years, months or days

3. (a) PRINT FULL NAME Laura B. Neill

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FM 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased: April (Month) 5 (Day) 1873 (Year)

8. AGE: Years 71 Months 0 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace Lafayette Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Housewife

12. Name Robert Mueh

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name Farmilia Oldham

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Chas Neill

(b) Address Grain Valley Mo.

17. (a) Buried (b) Date thereof 6-2-44 (Month) (Day) (Year)

(c) Place: burial or cremation Libby Mo

18. (a) Signature of funeral director Mrs G B Wilberson

(b) Address Blue Springs Mo

19. (a) June 3-44 (b) Mrs John Lawson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Grain Valley (Rural) (If outside city or town limits, write "RURAL")
(d) Street No. S. 1 st (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31 year 1944 hour 5 minute 20 A M.

21. I hereby certify that I attended the deceased from April 13 1944 to May 31 1944
that I last saw her alive on May 30 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Greening of the heart with infarction
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

23. Signature Dr. J. H. Anderson (Mean of injury)

Address Independence Mo Date signed 5/31/44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered-Apprentice No.....
working under my personal supervision.

Signed.....

R. B. Clark

Licensed Embalmer No.....

2353

P. O. Address.....

Blue Springs, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.